Clinical Laboratory Requisition Forms

Various requisition forms are available by calling the laboratory at 800-821-7284:

The standard laboratory request form, preprinted with your account information; all clinical testing can be ordered with this form.

A specific form for Chlamydia/gonorrhea screening only; this form collects additional information for public health program planning.

A newborn screening panel form; this form contains the dried blood spot collection kit.

Examples of each form are included on the following pages, as well as specific instructions on filling out the Chlamydia/GC and Newborn Screening forms.

General Instructions:

Please fill the forms out completely to include (at a minimum):

Patient Last Name or anonymous identifier (required)
Patient First Name
Patient ID #
Date of Birth
Gender
Medicaid # (if applicable)
NPI (or UPIN) # of Physician/Clinician (preferred)
Physician/Clinician Name (if NPI is not provided)
Specimen Collection Date (required)
Date of Onset of Illness (for serology and molecular testing)
Source of Specimen (If source is serum, indicate if the serum is acute, convalescent, or a screen only)
Test(s) Ordered

NOTE: Forms are read using an optical scanning device. Please print information clearly in boxes indicated. Do not use preprinted labels or stamps.

Standard Laboratory Testing Requisition Form

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Public Health Laboratory
P.O. Box 4369 Helena, MT 59604-4369
(406) 444-3444 (800) 821-7284 CLIA ID #27D0652531

PATIENT INFORMATION

LAST NAME

FIRST NAME

PATIENT ID #

DATE OF BIRTH / /

GENDER ☐ Male ☐ Female

MEDICAID #

PROVIDER INFORMATION

PHYSICIAN / CLINICIAN NAME

UPIN #

LAB USE ONLY

TEST(S) REQUESTED INFORMATION

Serology:

- ☐ TORCH Panel IgG
- ☐ Tick Borne Disease Panel
- ☐ Hepatitis Acute Panel
- ☐ Blood Lead
- ☐ Brucella Antibody
- ☐ CTFV IgG Serology
- ☐ Cytomegalovirus IgG Antibody
- ☐ Cytomegalovirus IgM Antibody
- ☐ Fluorescent Treponemal Antibody (FTA-ABS)
- ☐ Hantavirus IgG & IgM Serology
- ☐ Herpes Simplex Virus IgG Serology
- ☐ HIV-1 Antibody
- ☐ Legionella IgG Serology
- ☐ Mumps IgG Serology
- ☐ Q Fever IgG Serology
- ☐ RMSF IgG Serology
- ☐ Rubella IgG Antibody
- ☐ Rubella IgM Antibody
- ☐ Rubeola (Measles) IgG Antibody
- ☐ Rubeola (Measles) IgM Antibody
- ☐ Syphilis Serology
- ☐ Syphilis Serology, Quantitative
- ☐ Toxoplasma IgG Antibody
- ☐ Toxoplasma IgM Antibody
- ☐ Tularemia Antibody
- ☐ Varicella Zoster Virus IgG Serology
- ☐ West Nile Virus IgM Serology
- ☐ West Nile Virus IgG Serology
- ☐ Hepatitis B Surface Antigen
- ☐ Hepatitis B Surface Antibody
- ☐ Hepatitis B Total Core Antibody
- ☐ Hepatitis B Core IgM Antibody
- ☐ Hepatitis A IgM Antibody
- ☐ Hepatitis C Antibody
- ☐ HCV RNA Quantitation

Surveillance Cultures (no charge):

- ☐ GC Confirmation/Susceptibility
- ☐ Salmonella/Shigella/E. coli
- ☐ ESBL Confirmation
- ☐ MRSA Confirmation
- ☐ VRE Confirmation
- ☐ Influenza Confirmation

Chlamydia Culture:

- ☐ Chlamydia Culture

Virus Culture:

- ☐ Respiratory Virus Isolation
- ☐ Enteric Virus Isolation
- ☐ CNS Virus Isolation
- ☐ Virus Isolation
- ☐ Cytomegalovirus Isolation
- ☐ Herpes Simples Virus Isolation
- ☐ Varicella Zoster Virus Isolation
- ☐ RSV Direct Detection

Nucleic Acid Amplification:

- ☐ Chlamydia and Gonorrhea (APTIMA)
- ☐ Chlamydia Only (APTIMA)
- ☐ Gonorrhea Only (APTIMA)
- ☐ Varicella Zoster PCR
- ☐ Enterovirus NAAT
- ☐ Influenza A PCR
- ☐ Influenza B PCR
- ☐ Adenovirus PCR
- ☐ Herpes Simplex Virus PCR
- ☐ Norovirus PCR
- ☐ M. tuberculosis Direct Amplification
- ☐ Bordetella pertussis/parapert PCR

Microbiology:

- ☐ Autoclave Monitoring-BT Test
- ☐ Chemclave Monitoring Test
- ☐ Enteric Panel Culture
- ☐ Campylobacter screen
- ☐ Yersinia screen
- ☐ Vibrio screen
- ☐ EHEC (STEC) Toxin Test
- ☐ Clostridium difficile Toxin Test
- ☐ Bacteriology Culture/ID, Aerobic
- ☐ Bacteriology Culture/ID, Anaerobic
- ☐ BT Agent Rule Out (list in Comments)
- ☐ Bordetella pertussis Culture/ID
- ☐ Legionella Direct Detection
- ☐ Legionella Culture/ID
- ☐ Neisseria gonorrhoeae Culture/ID
- ☐ Streptococcus Group A Culture Screen
- ☐ TB Mycobacteria Culture/ID
- ☐ Fungus Culture/ID
- ☐ Ova and Parasite Exam
- ☐ Cryptosporidium/Cyclospora Detection
- ☐ Malaria Screen
- ☐ Modified Acid Fast Stain

Test(s) Requested (If Not Listed)

Comments / Pertinent Information / Symptoms

SPECIMEN COLLECTION DATE / /

DATE OF ONSET / /

SPECIMEN SOURCE

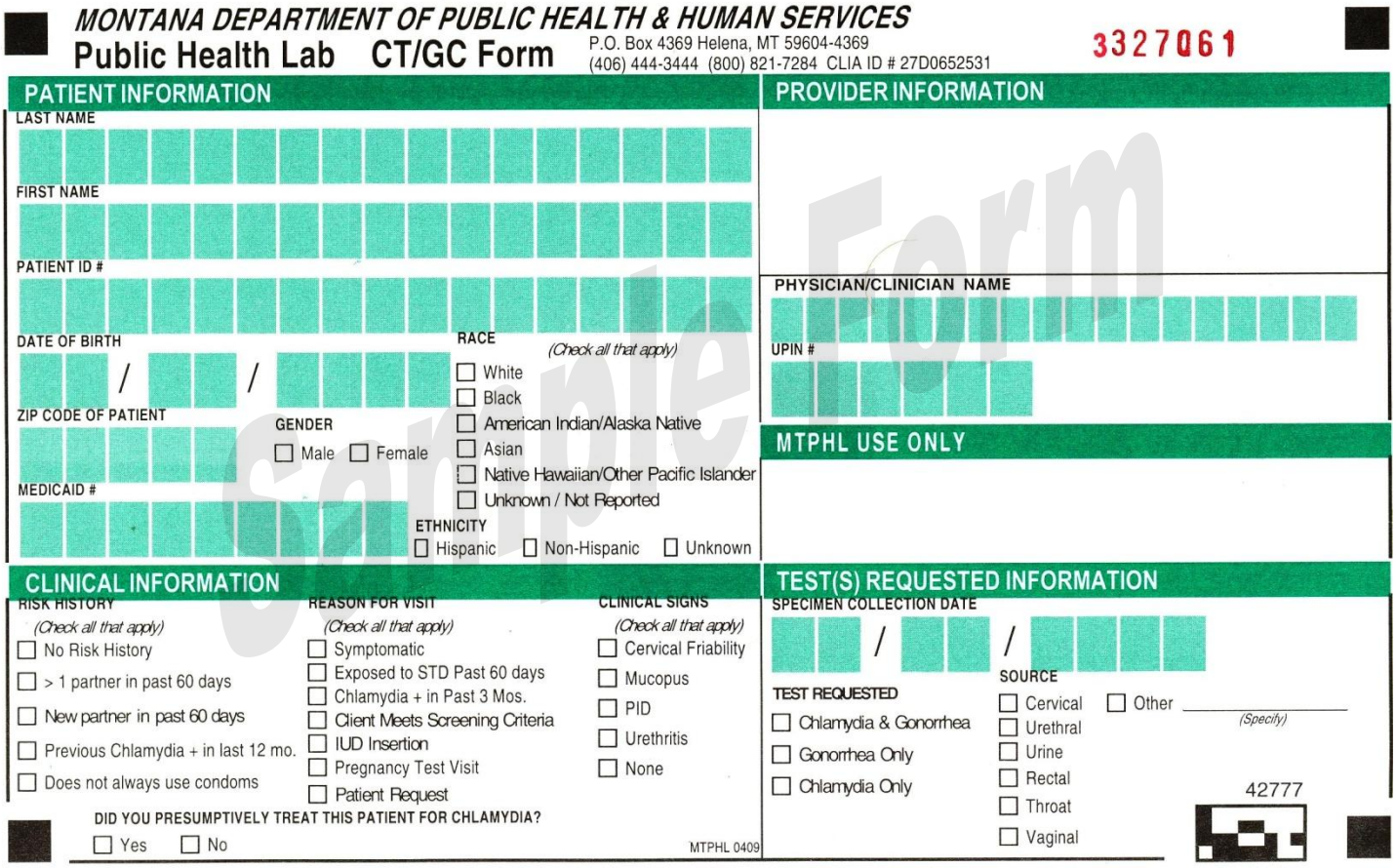
- ☐ Throat/NP Swab
- ☐ Cervical Swab
- ☐ CSF
- ☐ Stool/Rectal Swab
- ☐ Urethral Swab
- ☐ Bronchial Washings
- ☐ Lesion Swab
- ☐ Sputum
- ☐ Other _____
- ☐ Urine
- ☐ EDTA Blood
- ☐ Pleural Fluid (Specify)
- ☐ Acute Serum
- ☐ Convalescent Serum
- ☐ Serum Screen Only

38558

DPHHS PHL 0808

Chlamydia/GC Screening Requisition Form

This form collects additional demographic information for public health program planning. Please submit this completed form with requests for Chlamydia screening.



MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Public Health Lab CT/GC Form
P.O. Box 4369 Helena, MT 59604-4369
(406) 444-3444 (800) 821-7284 CLIA ID # 27D0652531
3327061

PATIENT INFORMATION
LAST NAME
FIRST NAME
PATIENT ID #
DATE OF BIRTH / /
ZIP CODE OF PATIENT
MEDICAID #
GENDER ☐ Male ☐ Female
RACE (Check all that apply)
☐ White
☐ Black
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Unknown / Not Reported
ETHNICITY ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

PROVIDER INFORMATION
PHYSICIAN/CLINICIAN NAME
UPIN #

MTPHL USE ONLY

CLINICAL INFORMATION
RISK HISTORY (Check all that apply)
☐ No Risk History
☐ > 1 partner in past 60 days
☐ New partner in past 60 days
☐ Previous Chlamydia + in last 12 mo.
☐ Does not always use condoms

REASON FOR VISIT (Check all that apply)
☐ Symptomatic
☐ Exposed to STD Past 60 days
☐ Chlamydia + in Past 3 Mos.
☐ Client Meets Screening Criteria
☐ IUD Insertion
☐ Pregnancy Test Visit
☐ Patient Request

CLINICAL SIGNS (Check all that apply)
☐ Cervical Friability
☐ Mucopus
☐ PID
☐ Urethritis
☐ None

DID YOU PRESUMPTIVELY TREAT THIS PATIENT FOR CHLAMYDIA?
☐ Yes ☐ No

MTPHL 0409

TEST(S) REQUESTED INFORMATION
SPECIMEN COLLECTION DATE / /
TEST REQUESTED
☐ Chlamydia & Gonorrhea
☐ Gonorrhea Only
☐ Chlamydia Only
SOURCE
☐ Cervical ☐ Other _____ (Specify)
☐ Urethral
☐ Urine
☐ Rectal
☐ Throat
☐ Vaginal

42777

Sample Form

Chlamydia Lab/Data Form Instructions

PATIENT NAME: Please print clearly. LAST NAME first. The last name will be transformed into a numeric code and combined with date of birth to create a confidential ID code for date transmission.

DATE OF BIRTH: Please record in the MONTH/DAY/YEAR fashion. This field MUST be completed.

PATIENT ZIP CODE: Please print clearly and record the 5 digit zip code of the patient's residence. This will be used to determine the geographic distribution of Chlamydia.

SPECIMEN COLLECTION DATE: This is the date the patient was seen at the clinic and a specimen for Chlamydia testing was obtained. Please record in the MONTH/DAY/YEAR fashion. This field MUST be completed.

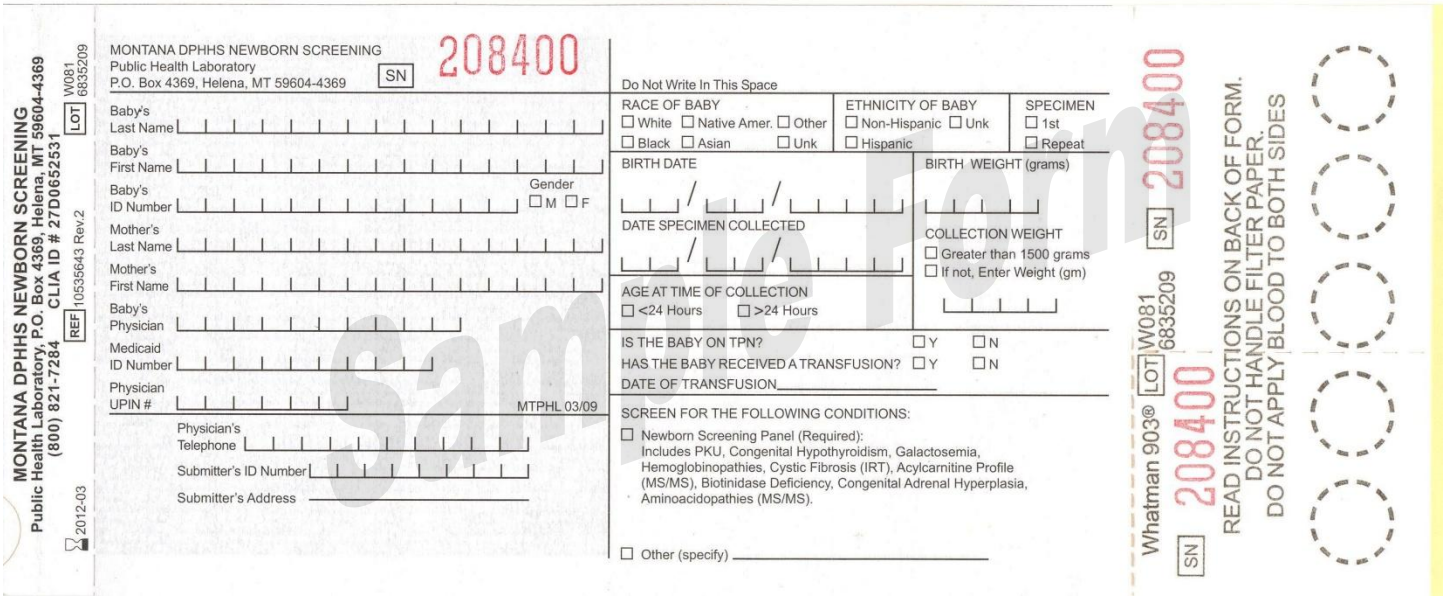
TEST REQUESTED: You have the option of picking the combination Ct/GC test, or each one individually

SOURCE: Please select only one source.

RACE: (check all that apply) This information is obtained from the patient.	__White __Black __ American Indian/Alaska Native __Asian __ Native Hawaiian/Other Pacific Islander __Unknown / Not Reported
ETHNICITY: (check only one box) If unsure, ask the patient if they consider themselves to be Hispanic.	__ Hispanic __ Non-Hispanic __ Unknown
RISK HISTORY: (check all that apply) First three factors are self-explanatory. Previous Chlamydia + refers to whether the patient has had a positive Chlamydia test during the past year.	__ No Risk History __ >1 partner past 60 days __ New partner past 60 days __ Previous Chlamydia + in last 12 months __ Does not always use condoms
REASON FOR EXAM: (check all that apply) This information is obtained from the patient, or is determined by the clinician seeing the patient.	__ Symptomatic __ Exposed to STD Past 60 days __ Chlamydia + in Past 3 Mos. __ Client Meets Screening Criteria __ IUD insertion __ Pregnancy Test Visit __ Patient Request
CLINICAL SIGNS: (check all that apply) Cervical Friability refers to easily induced bleeding with the initial swab. Mucopus refers to yellow or green mucopurulent discharge from the cervix, PID refers to Pelvic Inflammatory Disease. Signs and symptoms suggestive of PID include: abdominal pain/tenderness on pelvic exam, vaginal discharge/bleeding, dysuria, fever and sometimes nausea or vomiting. Urethritis refers to urethral discharge or dysuria. None refers to absence of all of the above clinical signs on exam.	__ Cervical Friability __ Mucopus __ PID __ Urethritis __ None
TREATMENT: Based on clinic/epidemiologic assessment, was the patient sent home with medication (or prescription) to treat Chlamydia without waiting for Chlamydia test results?	Did you presumptively treat this patient for Chlamydia? __ Yes __ No

Newborn Screening Requisition Form

This form has attached special filter paper for collection of the blood spots.



All information contained on the form must be completed.

Complete the patient information (name, sex, ID#, race, and ethnicity) as well as the mother's name and baby's physician.

Mark the specimen as to whether this is the first screen performed on the baby, or repeat screen. If the baby was screened at the hospital, and then is followed up with a repeat test at the physician's office, mark the repeat box.

Accurately complete the birth date and specimen collection date. If the birth date and specimen date are only 1 day apart, and the >24 hour box is not marked, the baby will be assumed to be < 24 hours of age at the time of collection. Samples obtained from a child less than 24 hours old must be repeated.

Complete the birth weight in grams and mark if the collection weight is greater than 1500 grams. If the collection weight is not >1500 grams, enter the weight in grams in the blank provided. Samples obtained on a child < 1500 grams of weight must be repeated.

Answer the questions on transfusion history. In cases when the baby received a transfusion, please include the date of transfusion. Samples must be repeated 90-120 days post transfusion.

If the baby is on TPN (Total Parenteral Nutrition) at the time of collection, please indicate that on the form.

As of January 2008, the entire Newborn Screening panel is mandatory.

This same form can be used for monitoring Phenylalanine levels on patients with known PKU disease.

Montana Public Health Laboratory
Supply Order Form
Toll Free 800-821-7284 or FAX 406-444-1802

Facility / ATTN: _____

Street Address _____

City/State/Zip _____

Account Number: _____ Order Date: _____

Phone No: _____ Order Taken By: _____

Quantity **Supplies** Revised 03/2010

	Kits	Boxes	
_____	□	□	Chlamydia/GC Aptima **SWAB** Collection Kits (50/box) (for Cervical, Urethral, Rectal or Throat Specimens)
_____	□	□	Chlamydia/GC Aptima **URINE** Collection Kits (50/box)
_____	□	□	Chlamydia/GC Aptima **VAGINAL** Collection Kits (50/box)

_____Tuberculosis Transports

_____Ova & Parasite Transports

_____QuantiFERON Gold In Tube Collection Tubes (3 tubes/set)

_____Streptococcus Screening Kits

_____Capillary Blood Lead Collection Kits

_____Venous Blood Lead Collection Kits
□ Vacutainer □ Syringe/Needle

_____Cary-Blair Transport Medium (for stools and bacteriology cultures)

_____Microtest Transport Medium (for viral and chlamydia isolation)

_____Pertussis Transport Medium (for culture, not PCR)

_____Polyester Flexible Wire Swabs for Nasopharyngeal Collection

_____White Specimen Mailing Tubes

_____ Specimen Bags _____ Mailing Labels

_____Whirlpack Bags _____ Gloves _____ Ice Packs

Forms

_____Standard Laboratory Requisition Forms (blue)

_____Chlamydia / GC Request Forms (green)

_____Neonatal Screening Forms _____ Envelopes

_____Premarital Certificates

_____ Meat Inspection Testing Request Forms

Please Note: These supplies are the property of the State of Montana and are to be used only for business with the Montana Department of Public Health and Human Services.